

EXHIBIT N

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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COYNESS L. ENNIX, JR., M.D., as)
an individual and in his)
representative capacity under)
Business & Professions Code)
Section 17200 et seq.,)

Plaintiff,)

CERTIFIED COPY

vs.)

) No. C 07-2486

RUSSELL D. STANTEN, M.D., LEIGH)
I.G. IVERSON, M.D., STEVEN A.)
STANTEN, M.D., WILLIAM M.)
ISENBERG, M.D., Ph.D., ALTA BATES)
SUMMIT MEDICAL CENTER and Does 1)
through 100,)

Defendants.)

-----)
CONFIDENTIAL

CONFIDENTIAL PURSUANT TO PROTECTIVE ORDER

**DEPOSITION OF
RUSSELL D. STANTEN, M.D.**

December 12, 2007

REPORTER: BRANDON D. COMBS, RPR, CSR 12978

HANNAH KAUFMAN & ASSOCIATES, INC.

1 MR. EMBLIDGE: Q. Okay. Dr. Stanten, will
2 you briefly tell me your medical training background.

3 A. I to the Baylor College of Medicine where I
4 got my M.D. degree in 1985, then trained at UC Davis
5 Medical Center for my general surgery residency until
6 1991. I went then went to Brigham and Women's Hospital
7 in Boston where I did my cardiothoracic surgery training
8 until 1993. Then I went into practice after that.

9 Q. And what was the name of the practice group,
10 if you joined a practice group, what was the name of the
11 practice group you joined in '93?

12 A. At that time it was named Cardiothoracic
13 Surgical Associates.

14 Q. And who else was in that group?

15 A. Dr. Leigh Iverson and Roger Ecker.

16 Q. How do you spell Ecker?

17 A. E-c-k-e-r. And Dr. Mark Taylor.

18 Q. Okay. And if you could summarize how that
19 group evolved to the present day?

20 A. Dr. Taylor left and Dr. Mark Suzuki came on.
21 In 1996, Dr. Ecker retired; I believe it was 1996.
22 Dr. Suzuki left around the same time. Dr. Khan joined
23 the group around 1998.

24 Q. When did Taylor leave? I'm sorry.

25 A. '94.

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1 problems his patients had experienced and they had
2 difficulty sometimes reaching him.

3 Q. So it wasn't a problem that you had but a
4 problem that other people expressed to you?

5 A. And it would become a problem when I would
6 cover those patients.

7 Q. So there were times when you tried to reach
8 Dr. Ennix and you had trouble reaching him?

9 A. I think there were times like that.

10 Q. Do you recall any?

11 A. I don't remember any specific instances, no.

12 Q. Did these concerns give -- how would you
13 describe these concerns, serious, minor, how would you
14 categorize them?

15 A. I would describe them as moderate.

16 Q. And did you discuss your concerns about
17 Dr. Ennix with anyone else?

18 A. No.

19 Q. Did you discuss your concerns about him with
20 your brother?

21 A. No.

22 Q. And by your brother, throughout this
23 deposition, I mean Steven Stanten.

24 A. No. I did not discuss them with him.

25 Q. Did you discuss your concerns about Dr. Ennix

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1 surgeon?

2 A. I'm not aware of that.

3 Q. Are you aware at Doctors' Hospital of any ad
4 hoc committees being appointed to review surgeons?

5 A. I'm not aware of that, no.

6 Q. At Alta Bates Summit Medical Center, are you
7 aware of any cardiothoracic surgeon's cases being
8 reviewed by a body during the peer review process other
9 than the cardiothoracic peer review committee?

10 A. I am, with Dr. Ennix.

11 Q. Oh, okay. Other than with Dr. Ennix, are you
12 aware of any cardiothoracic surgeon's cases being
13 reviewed at Alta Bates Summit Medical Center outside of
14 the cardiothoracic peer review committee?

15 A. No. I'm not aware of that.

16 Q. Are you aware of any ad hoc committees being
17 appointed at Alta Bates Summit Medical Center to review
18 any surgeon other than Dr. Ennix?

19 A. I'm not specifically aware of that, no.

20 Q. Generally?

21 A. I had heard rumors about other cases, but I
22 really have no direct knowledge.

23 Q. You became chair of the cardiothoracic peer
24 review committee in 2004?

25 A. Yes.

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1 present any information he had, and to allow the members
2 to discuss the case from whatever perspectives they had.

3 Q. So it's fair to say in your estimation, that
4 was the best way to engage in peer review; correct?

5 A. For most of these cases, yes.

6 Q. Were there exceptions?

7 A. I don't remember any specific exceptions.

8 Q. Did Dr. Isenberg ever express to you concerns
9 that the way in which the cardiothoracic peer review
10 committee reviewed cases was not the best way to engage
11 in peer review?

12 A. I recall him having discussion with me, but I
13 don't recall him making any specific suggestions for
14 change or any other specific modifications, no.

15 Q. Have you made any changes in the way you
16 conduct peer review with the cardiothoracic peer review
17 committee since 2004?

18 A. I would say I'm still evolving how I go about
19 running the committee, but I don't think there have been
20 any substantial changes, no.

21 Q. Other than Dr. Isenberg, has anyone else
22 expressed concerns to you that the way in which the
23 cardiothoracic peer review committee conducts its peer
24 review is not the best way to conduct peer review?

25 A. First of all, I don't accept the premise of

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1 that question.

2 Q. Excluding Dr. Isenberg and what he may or may
3 not have said to you, has anyone ever expressed to you a
4 concern that the way in which the cardiothoracic peer
5 review committee conducts peer review is not the best
6 way to conduct peer review?

7 A. I still take issue with the way that question
8 is phrased. He asked about the way we perform it, he
9 didn't necessarily express concern, but he did ask about
10 the methods and asked me to review the methods.

11 I believe Dr. Steven Stanten may have asked me
12 some general questions along the same lines, but again,
13 I believe they were along the similar lines that I
14 described.

15 Q. Asking you about the process?

16 A. About the process that we undergo.

17 Q. And has there been anyone else with whom
18 you've had discussions about the process of peer review
19 at the cardiothoracic peer review committee?

20 A. Not that I recall, no.

21 Q. Did Dr. Steven Stanten ever ask -- did
22 Dr. Steven Stanten ever suggest that the process change?

23 A. I don't recall anybody making specific
24 suggestions for change or modification of it, no.

25 MR. EMBLIDGE: Let's take a short break.

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1 A. He's African American.

2 Q. And what about Garfield Bryant?

3 A. African American.

4 Q. Other than Dr. Ennix's case, are you aware of
5 any situation where the surgery peer review committee
6 did not accept the conclusion of a cardiothoracic
7 surgeon's review of a cardiothoracic surgeon's cases?

8 MS. McCLAIN: Objection. Lack of foundation.

9 THE WITNESS: I'm not aware of any other
10 cases, no.

11 MR. EMBLIDGE: Q. Minimally invasive surgery,
12 when did it first start at the Alta Bates Summit Medical
13 Center?

14 MS. McCLAIN: Objection. Vague.

15 MR. EMBLIDGE: Q. In the cardiothoracic
16 world.

17 A. Could you repeat the question, please.

18 Q. What do you understand minimally invasive
19 surgery to be?

20 A. Minimally invasive is a very broad category of
21 surgery defined differently by all different surgeons.

22 Q. So I want to make sure we're talking about the
23 same thing. How would you define the -- how would you
24 describe the four cases that Dr. Ennix had in terms of
25 minimally invasive? Is it a subset of minimally

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1 A. Yes. When we decided to proceed with the
2 technique, I felt that we should have one surgeon who
3 would be the primary surgeon for the majority of the
4 initial cases to develop the skill and expertise needed.
5 Dr. Khan put a lot of work and time into developing that
6 expertise and I felt it was important to support him in
7 doing that and that's how things evolved.

8 Q. Have you experienced any complications in
9 minimally invasive cases like these?

10 MS. McCLAIN: Objection. Vague, compound.

11 THE WITNESS: Yes.

12 MR. EMBLIDGE: Q. What types of
13 complications?

14 A. Complications where -- one complication was
15 bleeding, for which I did a sternotomy to control the
16 bleeding.

17 Q. Have you experienced any other complications
18 in performing these kind of minimally invasive
19 procedures?

20 A. One complication was a conversion to a
21 sternotomy just to assist with the technical performance
22 of the operation.

23 Q. Any others, any other complications?

24 A. Nope.

25 Q. So other than bleeding and conversion, you

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1 haven't experienced any other complications in the
2 minimally invasive procedures you've performed?

3 A. Those complications were actually things that
4 were taken care of at the time of surgery, so really
5 post-operatively, I'm not aware of any other
6 complications that occurred that I can recollect.

7 Q. And have you experienced any complications in
8 any of the minimally invasive procedures on which you've
9 assisted?

10 MS. McCLAIN: Same objection.

11 THE WITNESS: I don't follow the patients that
12 aren't mine as closely. I am aware of some
13 complications with those patients.

14 MR. EMBLIDGE: Q. What kinds?

15 A. Bleeding and multi-organ failure.

16 Q. Any deaths?

17 A. I believe there's been a couple of deaths.

18 Q. Other than yourself and Dr. Khan, are there
19 other cardiac surgeons performing minimally invasive
20 procedures at Alta Bates Summit Medical Center?

21 A. Yes.

22 Q. Who?

23 A. Dr. Hon Lee and Dr. David Alyono perform
24 minimally invasive valve surgery.

25 Q. What did Dr. Lee and Dr. Alyono do to prepare

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1 for those procedures before beginning that?

2 A. I'm not aware specifically of what training
3 they underwent.

4 Q. Are you aware generally?

5 A. In general, I know that they had also traveled
6 to visit some programs when they do it and had observed
7 us in doing it.

8 Q. Other than that, are you aware of anything
9 else they did different to prepare?

10 A. No.

11 Q. Have you performed any of these types of
12 procedures at any other hospital besides Alta Bates
13 Summit?

14 A. No.

15 Q. So you've had at least one case where you had
16 to convert to a standard incision while performing a
17 minimally invasive procedure?

18 A. Yes.

19 Q. Have you had more than one?

20 A. Two that I recall.

21 Q. What was the reason for converting?

22 A. The same two I mentioned a minute ago.

23 Q. I remember you mentioning that one involved
24 converting to address bleeding.

25 A. Yes.

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1 carefully and I don't recall that there were any other
2 specific issues, no.

3 MR. EMBLIDGE: Q. Well, do you think your
4 patient selection of these two patients could be
5 questioned?

6 MS. McCLAIN: Objection. Calls for
7 speculation.

8 THE WITNESS: Not that I recall.

9 MR. EMBLIDGE: Q. In performing cardiac
10 procedures, not just minimally invasive procedures, have
11 you had to replace a mitral valve in a patient where
12 you've earlier repaired that same mitral valve?

13 A. Could you please repeat the question again.

14 Q. Have you had to replace a mitral valve in a
15 patient when you had earlier repaired the patient's
16 mitral valve?

17 MS. McCLAIN: Objection. Vague as to time.

18 THE WITNESS: Are you referring to minimally
19 invasive cases?

20 MR. EMBLIDGE: Q. Any kind of cases.

21 A. I can recall one time where I did that, yes.

22 Q. Have you had to replace a valve that you had
23 earlier repaired during the same procedure?

24 MS. McCLAIN: Objection. Vague.

25 THE WITNESS: Yes.

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1 MR. EMBLIDGE: Q. And have you had to replace
2 a valve that you had earlier repaired within, say, three
3 or four months?

4 A. Yes.

5 Q. And let's talk about the replacement within
6 the same procedure where you repaired. What caused
7 that?

8 A. In the course of doing a mitral valve repair,
9 the surgeon has to assess how successful that area
10 repair is at the conclusion, and if he judges that the
11 repair is not adequate, then he has the option of either
12 re-repairing the valve or replacing it, and I've had
13 that circumstance occur.

14 Q. Approximately how many times?

15 A. A couple times.

16 Q. And do you think there's anything outside the
17 standard of care in a surgeon looking at the outcome of
18 a repair procedure and deciding it was in the patient's
19 best interest to replace the valve?

20 MS. McCLAIN: Objection. Compound, vague,
21 lacks foundation.

22 THE WITNESS: I'm not sure I understand your
23 question.

24 MR. EMBLIDGE: Q. What don't you understand?

25 A. I'd just like you to rephrase it again just

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1 MS. McCLAIN: May I have a continuing line of
2 objections to hypothetical questions that have no
3 relationship to actual cases?

4 MR. EMBLIDGE: Well, you can have a continuing
5 objection of incomplete hypothetical if you want.

6 MS. McCLAIN: I want the objections I've
7 already raised, which are lack of foundation, compound,
8 vague, improper hypothetical.

9 MR. EMBLIDGE: Yeah. I'll give you a
10 continuing objection on all those.

11 Q. What I'm trying to get at is, there are times
12 where you got a patient, you repair the valve and a few
13 months later the patient is still symptomatic or
14 develops symptoms, and you got to go in and replace that
15 valve. And the fact that you need to go in and replace
16 the valve that you earlier tried to repair, doesn't mean
17 that you did a lousy job the first time or selected the
18 wrong patient or used bad judgment, it's just that's one
19 of the things that sometimes happens. That's what I'm
20 trying to get at. That's not a question.

21 MS. McCLAIN: I can't resist, it is compound.

22 MR. EMBLIDGE: It's not a question, you don't
23 have to object to a nonquestion.

24 Q. So now let me try to ask the question. In
25 your experience as a cardiac surgeon, are there cases in

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1 which you've performed or observed where a patient
2 requires valve replacement surgery after an earlier
3 surgery to repair the same valve and where the need for
4 the replacement surgery is not something that you would
5 fault the surgeon for?

6 A. There are cases where that would be correct.

7 Q. Have you had cardiac surgery procedures with
8 an operating time that's exceeded seven hours?

9 A. Yes.

10 Q. Have you had cases involving minimally
11 invasive procedures where the operating time has
12 exceeded seven hours?

13 A. Not that I recall.

14 Q. Well, how about cases where you converted from
15 minimally invasive to standard incisions, have you had
16 cases like that that have exceeded seven hours?

17 A. No. Not that I recall.

18 Q. Do you think the fact that a case exceeds
19 seven hours means that a cardiac surgeon has used bad
20 judgment?

21 A. For a standard valve repair or replacement
22 case, having it exceed seven hours is a sign of some
23 problem.

24 Q. And could the problem be something other than
25 bad judgment?

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1 period of time.

2 Q. What types of cases can you recall where you
3 were the lead surgeon where the operating time exceeded
4 seven hours?

5 A. A difficult reoperation requiring multiple
6 combined procedures, such as a multi-valve replacement
7 or a multi-valve replacement with coronary artery bypass
8 grafting or all of those in combination with an aortic
9 reconstruction could certainly last that long.

10 Q. Is that what you recall being the types of
11 cases of your own that have lasted beyond seven hours?

12 A. I would say of my own or that I've observed.

13 Q. Approximately how many cases have you assisted
14 on where the operating time has exceeded seven hours?

15 A. Be very hard for me to give you an accurate
16 number. I'd only be guessing, and I would guess that it
17 may be 20 or possibly a little bit more than that over
18 the course of my career.

19 Q. And did those cases where you were assisting,
20 did they involve something other than multiple valve
21 replacements or aortic reconstruction?

22 A. Or multi-valve replacement with coronary
23 bypass grafting, I can't recall specific cases, and I'd
24 only be speculating.

25 Q. Did you ever assist Dr. Ennix in a case that

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1 present expressed concerns, did you have any other
2 reason for concluding that there was an individual
3 physician skill/judgment issue in these cases?

4 A. Could you repeat the question, please.

5 MR. EMBLIDGE: Why don't you read it back.
6 (Record read by the reporter.)

7 MS. McCLAIN: Objection. Misstates the
8 witness's testimony. The testimony was severe
9 complications in multiple patients.

10 THE WITNESS: The clustering of severe
11 complications, severe and life-threatening
12 complications, in these patients led me to conclude what
13 I stated.

14 MR. EMBLIDGE: Q. Have you ever had severe
15 complications with multiple patients in a one- or
16 two-month period of time?

17 MS. McCLAIN: Objection. Vague, compound,
18 lacks foundation.

19 THE WITNESS: Probably, but I don't recall
20 specifically.

21 MR. EMBLIDGE: Q. In your observations, have
22 other cardiac surgeons at Summit experienced severe
23 complications in patients within a one- to two-month
24 period of time?

25 MS. McCLAIN: Same objections.

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1 THE WITNESS: I believe so, yes.

2 MR. EMBLIDGE: Q. Have, to your knowledge,
3 any of those other cardiac surgeons ever had those
4 cluster of cases reviewed outside of the cardiothoracic
5 peer review committee?

6 MS. McCLAIN: Objection. Lack of foundation,
7 compound, incomplete hypothetical.

8 THE WITNESS: I can't recall any other
9 situations where there was a cluster of these severe
10 technical complications over that short a period of time
11 that required review by the cardiothoracic peer review
12 committee or any other body.

13 MR. EMBLIDGE: Q. That wasn't what I asked.
14 You said that you believe that there have been
15 other cardiac surgeons who have had severe complications
16 with multiple patients during a one- to two-month period
17 of time.

18 As to those cardiac surgeons and those cluster
19 of cases, have any of them, to your knowledge, been
20 reviewed outside of the cardiothoracic peer review
21 committee?

22 MS. McCLAIN: Same objection.

23 THE WITNESS: Not that I'm aware.

24 MR. EMBLIDGE: Q. Now, the next paragraph,
25 and I'm now on the second full paragraph on page 1741,

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1 A. I don't recall who the other surgeon is.

2 Q. Further down in that column, then the next
3 bullet point towards the end of the next bullet point,
4 it says -- oh, well, actually, it refers to a reviewer
5 and the chair. Do you see that?

6 A. You're talking about the left column, second
7 bullet point, middle of that paragraph?

8 Q. Yes.

9 A. Yes, I do see that.

10 Q. Is the reviewer Hon Lee?

11 A. My presumption is that that's referring to
12 Dr. Hon Lee.

13 Q. And the chair is your brother?

14 A. That's my presumption.

15 Q. Then it says, the reviewer suggested a
16 multi-disciplinary group be convened to evaluate the
17 processes surrounding minimally invasive cardiac
18 surgeries.

19 Was such a group convened?

20 A. I'm not aware of one.

21 Q. Then if you go back to the other column under
22 conclusions, recommendations, look at the third bullet
23 point. There's a discussion here about mitral valves
24 and aortic valves and what are more difficult. What's
25 your opinion on that subject?

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1 physician reviewer's findings that issues with the cases
2 were of documentation, not care.

3 Are you aware of any other instance in which
4 the surgery peer review committee did not accept the
5 findings of a physician reviewer?

6 A. I'm not aware of any other cases.

7 Q. Then it says, the committee did not determine
8 a care classification on the two specific cases. You
9 see that?

10 A. Yes.

11 Q. Isn't it typical that if the surgery peer
12 review committee is reviewing a case for care issues
13 that it makes a care classification?

14 A. Not necessarily, no. Many cases are discussed
15 in peer review committee, and further decisions,
16 information, and other input is required before
17 determination is made.

18 Q. Okay. And then it goes on to say on the next
19 page, members felt physician specific concerns included
20 final care determinations for the cases should be
21 reconsidered by the officers. Do you see that?

22 A. Yes.

23 Q. The officers mean the medical staff officers;
24 correct?

25 A. Yes.

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1 A. I know who the cardiac surgeons were.

2 Q. Were any of them officers?

3 A. Dr. Iverson was a member of the medical
4 executive committee at one point, I'm not aware that he
5 was a member at that time, but I don't recall the
6 specific times when he was a member versus when this
7 occurred.

8 Q. Can you recall any other instance where the
9 surgery peer review committee deferred making a final
10 care determination to another body?

11 A. I was not involved in some of the surgical
12 peer review committee's final decisions, and I can't
13 testify to what they did or did not. I have no other
14 recollection of another case like that.

15 Q. Are you aware of any circumstance where either
16 the cardiothoracic peer review committee or the surgery
17 peer review committee deferred to the officers to make a
18 care determination?

19 A. I'm not aware of any other specific
20 circumstances.

21 Q. And then the last sentence of that paragraph
22 says, it was also recommended that X number of minimally
23 invasive procedures, no matter the surgeon, be reviewed.
24 Do you see that?

25 A. Yes.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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COYNESS L. ENNIX, JR., M.D.,
as an individual and in his
representative capacity under
Business & Professions Code
Section 17200 et seq.,
Plaintiff,

CERTIFIED COPY

vs.

Case No.: C 07-2486

RUSSELL D. STANTEN, M.D.,
LEIGH I.G. IVERSON, M.D.,
STEVEN A. STANTEN, M.D.,
WILLIAM M. ISENBERG, M.D.,
Ph.D., ALTA BATES SUMMIT
MEDICAL CENTER and Does 1
through 100,
Defendants.

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DEPOSITION OF RUSSELL D. STANTEN, M.D.
Wednesday, January 23, 2008
VOLUME II, Pages 121 - 282

REPORTED BY:
APRIL DAWN HEVEROH, CSR NO. 8759

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1 Q. Anything else?

2 A. No.

3 Q. Did you talk to anybody about this case other
4 than your attorneys between the last time you had your
5 deposition taken and today?

6 A. No, I did not.

7 Q. And did you meet with your attorneys in
8 preparation for today's session?

9 A. I met --

10 Q. Don't tell me what you said, but just tell me
11 if you met.

12 A. I met earlier today.

13 Q. So between your last session and today, how
14 much time have you spent with your attorneys preparing
15 for your deposition testimony?

16 A. 30 minutes.

17 Q. Okay. There's been some confusion. Well,
18 there's been some confusion in my mind as to the process
19 of peer review at the cardiothoracic peer-review
20 committee.

21 Since we last met I have learned that
22 Dr. Isenberg was troubled by the process of peer review
23 of the cardiothoracic peer-review committee, at least in
24 part because, as he understood it, when the
25 cardiothoracic peer-review committee was deliberating

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1 about care issues regarding Physician A, Physician A was
2 in the room during those deliberations; that
3 Dr. Isenberg was troubled by that.

4 Doctor, I believe you testified somewhat
5 contrary to that the last time we got together, but when
6 I took Dr. Iverson's deposition, he specifically said
7 that in his tenure as chair of the committee and while
8 being a member of the committee under your tenure, he
9 believed that the doctor whose case was being
10 deliberated regarding was not in the room.

11 MS. McCLAIN: Objection. Lacks foundation as
12 to what Iverson said.

13 MR. EMBLIDGE: Q. Accepting as true what I've
14 just told you, since you weren't at those depositions,
15 what is your experience in that regard in terms of how
16 the cardiothoracic peer-review committee, let's say,
17 from 2000 to 2006, handled those kinds of issues?

18 A. My belief was whenever there was a case being
19 reviewed where there was a need for determination of
20 corrective action, that we would ask -- my policy was to
21 ask the surgeon to leave the room, but I don't -- as a
22 determination was being made. That is to say, they
23 would be there to present their portion of the case, and
24 then they would be asked to leave the room while the
25 remaining people on the committee would make a

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1 determination about that. That was the model I had in
2 mind. But as to how often or whether I ever had to
3 employ that, my memory's not good enough to tell you
4 specific instances or dates or times, or whether there
5 were any cases that I can recall at all or not.

6 Q. Okay. That was the model you had in mind
7 while you were the chair; is that correct?

8 A. Right.

9 Q. Now, before you were the chair, you were a
10 member of the committee, right? You have to answer
11 audibly.

12 A. Yes.

13 Q. When you were a member of the committee, was
14 it your understanding that that was the model that was
15 employed at that time, as well?

16 A. I honestly don't have a strong recollection of
17 those meetings, how Dr. Iverson ran them, and I can't
18 give you -- and I'm reluctant to guess at what my memory
19 might have been because I really don't have strong
20 memories of how it was done.

21 Q. Let me put it this way: Do you have a
22 recollection different from Dr. -- what I've represented
23 to be Dr. Iverson's recollection, that is, that the
24 physician under review would be excused from the room
25 during deliberations?

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1 MS. McCLAIN: Objection. Lack of foundation.

2 THE WITNESS: I don't have a different
3 recollection than that.

4 MR. EMBLIDGE: Q. And do you have any
5 understanding as to -- well, do you have any
6 understanding as to how Dr. Isenberg would have come to
7 believe that the physician remained in the room during
8 deliberations?

9 A. I really don't know how he arrived at that
10 conclusion. He was never present at a peer-review
11 meeting that I can remember.

12 Q. Was that ever a subject that he discussed with
13 you?

14 A. I know that he discussed some aspects of how
15 we do peer review. My recollection is that he asked me
16 how we do it, and I described it to him, but I don't
17 know exactly when that conversation occurred, and I
18 don't recall him making other suggestions about it at
19 that point, except possibly to just express concern
20 about our ability to perform all of the duties.

21 Q. What do you mean by your ability to perform
22 all of the duties?

23 A. Whether he felt -- he asked me, as I recall,
24 whether I felt we could perform the duties that we were
25 charged with, and my recollection is that I answered

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1 that I could.

2 Q. Was it your understanding that his concern had
3 to do with the volume of work or something else?

4 A. I don't think he -- I don't recall him
5 specifically mentioning any specific concerns.

6 Q. We talked at the last session, or began to
7 talk, about some of the issues relating to the
8 four minimally-invasive cases. The first case involved
9 a patient who had a history of schizophrenia.

10 Are you aware of that?

11 A. I'm aware of one of the four patients having a
12 history of schizophrenia. I don't recall which order
13 patient he was.

14 Q. In your experience as a cardiac surgeon at
15 Summit, have you had occasion to perform surgery on
16 patients who are suffering from mental disorder?

17 A. Yes.

18 Q. And in your experience, if -- well, do you
19 always obtain a psychiatric consultation before
20 operating on such a patient?

21 A. No.

22 Q. Do you have any reason to believe it would be
23 improper at Summit for a cardiac surgeon to perform
24 heart surgery on a patient suffering from schizophrenia
25 if the cardiac surgeon explains all the risks involved

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1 available, and I don't know if I would be surprised or
2 not surprised.

3 MR. EMBLIDGE: Q. At Summit in 2004, how many
4 cardiac surgeons were practicing?

5 A. Six.

6 Seven. Excuse me. Seven. Maybe I guess
7 there's eight. Eight.

8 Q. Does that include Kaiser?

9 A. That includes Kaiser.

10 Q. Only eight. Okay.

11 Would you -- strike that.

12 Those eight cardiac surgeons all served on the
13 cardiothoracic surgery peer-review committee at a time
14 when you were the chair, correct?

15 A. Yes.

16 Q. Are there any of those cardiac surgeons that,
17 in your work with them, you believe could not have done
18 a fair and objective review of Dr. Ennix as a member of
19 the ad hoc committee?

20 A. I believe they potentially could have done a
21 fair review of him.

22 Q. And why do you use the word "potentially"? Do
23 you have any hesitation?

24 A. No.

25 Q. Now, you -- you appeared before the ad hoc

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1 difference between the mortality rate between those
2 two surgeons, right?

3 A. Yes.

4 Q. But you would not draw -- you would find that
5 data to be inconclusive based on the lack of sample size
6 and risk adjustment, wouldn't you?

7 MS. McCLAIN: Objection. Lack of foundation,
8 incomplete hypothetical, compound, vague.

9 THE WITNESS: I would probably keep an eye on
10 the surgeon who had two deaths out of the first 10, but
11 I wouldn't necessarily arrive at the conclusion that he
12 was an inferior surgeon, no.

13 MR. EMBLIDGE: Q. And as far as statistically
14 sound data on mortalities, are you aware of any more
15 reliable data on surgeons in California than the data
16 compiled by the state of mortalities relating to CABG
17 procedures?

18 A. No.

19 Q. Let's go to the third page of the October 27th
20 document, please. The committee asked you about
21 Dr. Ennix's decision-making skills, and there's a
22 discussion about port cases and other cases.

23 Do you see that?

24 A. Yes.

25 Q. Is it a fair summary to say the issues you

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1 A. Proctoring occurs oftentimes when a new
2 surgeon joins the staff.

3 Q. And it can also occur as part of a corrective
4 action, right?

5 A. Proctoring can occur under many different
6 circumstances.

7 Q. Can you give me some other examples?

8 A. There could be voluntary proctoring or
9 mandatory proctoring.

10 Q. Okay. So you've got a new surgeon, you've got
11 an existing surgeon who voluntarily gets proctored and
12 an existing surgeon who involuntarily has proctoring; is
13 that correct?

14 A. Yes.

15 Q. And have there been -- when you started
16 performing cardiac surgeries at Summit, did you have
17 proctoring?

18 A. Yes.

19 Q. And since you've been there, have other
20 surgeons, cardiac surgeons come on board who have had
21 proctoring?

22 A. Yes.

23 Q. Approximately how many cases of yours were
24 proctored when you began performing surgeries?

25 A. I believe it's in the range of 10 to 15.

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1 Q. And has that also been the range of cases that
2 you believe have been proctored for other surgeons who
3 have come on board?

4 A. Yes.

5 Q. What was your reason for concluding that you
6 didn't think Dr. Ennix's privileges should be removed?

7 A. I believed he had the ability to continue to
8 do coronary artery bypass grafting and standard approach
9 valve repair and replacement.

10 Q. And that was based on your years of working
11 with and observing him?

12 A. Yes.

13 Q. And assisting him in some of -- assisting him
14 in cases of those types, correct?

15 A. Yes.

16 Q. In your appearance before the committee, were
17 there particular individuals who seemed to be doing most
18 of the questioning, or was it all the committee members?

19 A. I believe it was all of the committee members.

20 Q. Did you have a sense, in appearing before the
21 committee on this occasion or the other occasions we've
22 discussed, that the committee seemed to be trying to get
23 you to say things that were unfavorable about Dr. Ennix?

24 A. No, I don't believe that was the case. I
25 think they gave me the opportunity to do that, but I

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1 indisputable. The coronary cases I felt were more
2 complicated because there were many issues involved, and
3 that one might have a difference of opinion about some
4 of the aspects of those. But at the same time, I felt
5 that the criticisms were valid.

6 Q. Okay. So coronary cases referred to the
7 six cases that weren't minimally-invasive, right?

8 A. Weren't minimally-invasive valve cases, yes.

9 Q. Now, apart from the criticisms that the NMA
10 had specific to Dr. Ennix, there were also some systemic
11 issues that the NMA raised, right?

12 A. Yes.

13 Q. And it states here that you say that -- and
14 I'm in the paragraph that begins with, "Dr. Stanten
15 noted that." Do you see that?

16 A. Yes.

17 Q. -- "that the system issues are valid."

18 What did you mean by that?

19 A. I'm not sure what I meant or that I even said
20 that, necessarily.

21 Q. Did you think the system issues that the NMA
22 raised were valid?

23 A. I thought some of them were and some of them
24 weren't, but I don't recollect exactly what they were.

25 Q. And then it says that you stated that a

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1 discussion with the cardiologists needs to take place
2 regarding how we make decisions about approach to cases.

3 What did you mean by that?

4 A. Discussing with cardiologists whether there
5 was the opportunity to have multiple additional reviews
6 prior to a final decision regarding whether a patient
7 should go to surgery for treatment of a problem or
8 should have an angioplasty to treat the problem or be
9 treated medically.

10 Q. What did you do following receipt of the NMA
11 report to see that discussions with cardiologists about
12 these issues took place going forward?

13 A. I approached some cardiologists, I believe,
14 and mentioned that, but I got a less than positive
15 response about it and feeling from them that there
16 wasn't an issue in this regard, and I did not pursue it
17 further.

18 Q. What cardiologist did you approach?

19 A. I don't recall, specifically. I think I
20 talked to several, but I don't remember who they were.

21 Q. Are there any that you can recall?

22 A. No.

23 Q. At the bottom of the page, one line up, it
24 says -- or it attributes to you the statement, "Some of
25 the problems they called technique are actually

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1 wasn't indicated, right?

2 A. Yes.

3 Q. Do you think Dr. Ennix did?

4 A. I don't know what his feelings were when he
5 made decisions to operate, whether he felt the risks
6 were too high but that he should or not. I can't really
7 testify to the state of his mind.

8 Q. And then in the next paragraph it says, "It
9 was noted that this systemic issue needs the most
10 attention."

11 From the best of your memory, is that
12 something you noted or something that committee members
13 noted to you?

14 A. This was stated in the NMA report and the
15 committee asked me about it. I felt it was a reasonable
16 idea that was worth pursuing, but even at the time that
17 I said this, I knew there would be some resistance among
18 the cardiologists to develop a formal method to
19 implement this. Some of it would just be the difficulty
20 in trying to implement a process like that.

21 Q. And it talks about bringing this to the
22 cardiology committee. Is there such a thing?

23 A. Yes.

24 Q. Did you take this issue to that committee?

25 A. No.

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1 Q. Why not?

2 A. I don't know why not.

3 Q. Are you aware of anybody that pursued this
4 issue with the cardiology committee?

5 A. I -- after my initial discussions with
6 cardiologists, I declined to pursue it further with the
7 cardiology committee at that time.

8 Q. Are you aware of anyone that pursued it with
9 the cardiology committee?

10 A. No.

11 Q. What was the resistance you received from the
12 cardiologists?

13 A. There was some question -- the implication was
14 that the cardiologists doing the intervention were not
15 skilled enough to be able to perform procedures or make
16 decisions, and my recollection is that the cardiologists
17 were not receptive to this idea, and the realities of
18 trying to implement some system that would allow
19 additional cardiology evaluation under emergent
20 circumstances was not a simple problem to solve, and no
21 one really had any ideas about how to solve it, so I
22 didn't pursue it beyond that.

23 Q. Do you think that would be -- establishing a
24 system like that would be an advantage for patients at
25 Summit?

STATE OF CALIFORNIA

I do hereby certify that the witness in the foregoing deposition was by me duly sworn to testify the truth, the whole truth, and nothing but the truth in the within-entitled cause; that said deposition was taken at the time and place therein stated; that the testimony of the said witness was reported by me, a Certified Shorthand Reporter and a disinterested person, and was under my supervision thereafter transcribed into typewriting; that thereafter, the witness was given an opportunity to read and correct the deposition transcript, and to subscribe the same; that if unsigned by the witness, the signature has been waived in accordance with stipulation between counsel for the respective parties.

And I further certify that I am not of counsel or attorney for either or any of the parties to said deposition, nor in any way interested in the outcome of the cause named in said caption.

IN WITNESS WHEREOF, I have hereunto set my hand the 27th
day of December, 2007.



Certified Shorthand Reporter

CSR No. 12978

STATE OF CALIFORNIA

I do hereby certify that the witness in the foregoing deposition was by me duly sworn to testify the truth, the whole truth, and nothing but the truth in the within-entitled cause; that said deposition was taken at the time and place therein stated; that the testimony of the said witness was reported by me, a Certified Shorthand Reporter and a disinterested person, and was under my supervision thereafter transcribed into typewriting; that thereafter, the witness was given an opportunity to read and correct the deposition transcript, and to subscribe the same; that if unsigned by the witness, the signature has been waived in accordance with stipulation between counsel for the respective parties.

And I further certify that I am not of counsel or attorney for either or any of the parties to said deposition, nor in any way interested in the outcome of the cause named in said caption.

IN WITNESS WHEREOF, I have hereunto set my hand the 22nd
day of February, 2008.

April D. Haverah
Certified Shorthand Reporter

CSR No. 8759